Claims Clues

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Modifier Indicates Multiple Transports

Emergency and non-emergency transportation providers may use a new AHCCCS-specific modifier when billing the AHCCCS Administration for multiple transports of the same recipient on the same day.

The "2X" modifier gives providers an additional billing option when submitting claims for multiple transports.

When multiple transports occur on the same day, only one base rate may be charged unless the additional transport(s) is (are) an identifiable separate service.

The following examples illustrate correct billing procedures.

Example 1:

Recipient transported from accident scene to hospital by ground or air ambulance. Ambulance remains at hospital while recipient is stabilized, then transports recipient to another hospital or to airport for transfer to another facility.

- Ground ambulance should bill one base rate, mileage, and waiting time.
- Air ambulance should bill one base rate and mileage.

Example 2:

Recipient transported from accident scene to hospital by ground or air ambulance. Ambulance leaves hospital and returns to base or takes another call. At hospital's request, ambulance returns to hospital to transport recipient to another hospital or to airport for transfer.

The provider may bill two base rates and mileage, using one of the following methods.

If the same HCPCS code is used to bill the base rate for both trips:

- Bill two units of the base rate on Line 1 of the HCFA 1500 claim form and total mileage on Line 2. No waiting time should be billed.

or

- Bill one unit of the base rate for the first trip on Line 1 of the claim form. Bill mileage on Line 2.
- Bill the base rate for the second trip on Line 3 (or on a separate claim) with the "2X" modifier. Bill the mileage on Line 4 (or on a separate claim) with the "2X" modifier. The modifier will prevent the trip from being denied as a duplicate service.
- No waiting time is allowed.

If a different HCPCS code is used to describe the second base:

- Bill one unit of the first base rate on Line 1, and bill mileage for the trip on Line 2.
- Bill one unit of the second base rate on Line 3, and bill mileage for the trip on Line 4.
- No waiting time is allowed.

If multiple non-ambulance transports are authorized for the same day, providers must bill the second (and any subsequent) trips using one of the following methods:

- Bill two units of the base rate on Line, and bill total mileage for both trips on Line 2.

or

- Bill one unit of the base rate for the first trip on Line 1, and bill mileage on Line 2.
- Bill the base rate for the second trip on Line 3 (or on a separate claim) with the "2X" modifier. Bill the mileage on Line 4 (or on a separate claim) with the "2X" modifier. □

Alpha Character Modifiers Not Allowed

AHCCCS does not accept the two-position alpha character transportation modifiers used by Medicare to indicate the origin and destination of a trip.

The alpha characters are D, E, G, H, I, J, N, P, R, S, and X.

These modifiers should not be used when submitting fee-for-service transportation claims to the AHCCCS Administration. □

EPO Billing Follows Medicare Guidelines

AHCCCS follows Medicare guidelines for billing for Erythropoietin (EPO) by free-standing and hospital-based dialysis facilities.

EPO administration must be billed on the UB-92 claim form with revenue code 634 (less than 10,000 units administered per dialysis treatment) or 635 (10,000 or more). If revenue code 635 is billed, documentation supporting the necessity for administering 10,000 or more units is required.

Enter hematocrit test results in Field 39, 40, or 41 using value code 49. EPO will not be reimbursed if the hematocrit results are greater than 36 per cent, unless medically justified.

Enter total units administered in Field 39, 40, or 41 using value code 68. Enter the number of times EPO is administered in Field 46.

Providers should calculate charges at $10 per 1,000 units rounded to the nearest hundred ($1 per 100 units).

Example: A recipient received dialysis seven times in a billing period. On five treatment days, 7,000 units of EPO were administered per treatment. At each of the other two treatments, the recipient received 12,000 units. The facility would bill as follows:

- Revenue code 634 = 5 units
- Revenue code 635 = 2 units
- Value code 68 and 59,000 units ([5 X 7,000] + [2 X 12,000])
- Charges = $590 (59 X $10)

If value code 49 is 36 per cent or less, documentation supporting revenue code 635 is approved by Medical Review, and EPO is administered in the dialysis facility by its staff, the provider will be reimbursed an extra $30 for each administration over 10,000 units.

In the previous example, reimbursement would be (2 X $30) + $590 = $650.

For self-dialyzing Method I patients at home, EPO may be ordered for one or two months. Revenue code 635 should be billed. Enter condition code 70 in any of Fields 24-30. Enter value code 68 and total units ordered in Field 39, 40, or 41.

Because the facility's staff did not administer EPO, the units field (Field 46) is left blank. No special documentation for revenue code 635 is required in this case. □

Coding Corner

The AHCCCS Administration has made the following changes to its Reference subsystem:

- AHCCCS coverage of P9610 end-dated 03/31/98; replaced by Q0162 effective 04/01/98
- Open end-dates for W0087 – W0089
- Code 90748 (Hepatitis B and HIB vaccine) is covered under the Vaccines for Children program. The code must be billed with the "VA" modifier.
- ICD-9 procedures 04.2 (Destruction of cranial and peripheral nerves) and 84.41 (Fitting of prosthesis of upper arm and shoulder) have been added to the Excluded Surgery List. These procedures will not qualify an inpatient hospital claim at the surgical tier.

Provider type 02 (Hospital)

- Add G0100; effective 04/01/97
- G0100 replaced by 87536; effective 04/01/98
- End date 00100 – 01999; all effective 01/01/95

Provider type 04 (Laboratory)

- Add G0100; effective 04/01/97

Provider type 05 (Clinic)

- End date 00100 – 01999; all effective 01/01/98
- Add Z3723; effective 01/01/95
- End date 00110 – 09999; all effective 01/01/98

Provider type 07 (Dentist)

- Add 11012, 11040; both effective 01/01/97
- Add 99214, 99239; both effective 01/01/96

Provider type 09 (CNM)

- Add Modifier 80 to 59514 (if credentialed as surgical first assistant); effective 01/01/98

Provider type 10 (Podiatrist)

- Add 97750; effective 01/01/98

Provider type 14 (Physical therapist)

- Add 97002; effective 01/01/98
- End date 92502-92504, 92511-92525, 92531-92598, 95832; all effective 05/01/98

Provider type 18 (PA)

- Add G0008, G0009; both effective 01/01/96
- Add 86588; effective 01/01/98

Provider type 19 (RNP)

- Add 82950, 82951; both effective 01/01/97
- Add G0008, G0009, 90730, 99025; all effective 01/01/96

Provider type 43 (ASC)

- Add V2799; effective 01/01/96

Provider type 72 (RBHA)

- Add A0100, A0110, A0130, Z3716, Z3717; effective 01/01/95 □